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Original ARTICLES

THE TREATMENT OF CHRONIC AMEBIASES WITH CAMOFORM

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THE following study is presented to evaluate the effectiveness of treating chronic amebiasis with Camoform*. Since the introduction of this drug, it has been administered to sixty-four patients who have had a diagnosis of this condition. Before beginning such a discussion it may be well to present some kind of concept of what might be termed "Chronic Amebiasis." To begin with it is a controversial subject and seems destined to continue as such, mainly because of the difficulty in confirming the diagnosis. This depends upon identifying the organism in the stools. And such an examination is unreliable, because it is only under certain ideal conditions that the organisms can be found in a routine stool examination. Time does not permit further elaboration on this point. Another reason is that there is so much misunderstanding about both the symptoms and the treatment.

When amebiasis is mentioned it is invariably associated with dysentery, and dysentery actually is a very rare occurence in chronic amebiasis. To continue the misunderstanding, or what might better be termed illogical reasoning; Patients with amebiases are often instructed not to eat lettuce. Lettuce seems to bare the brunt of the method by which ameba is contracted. If this were actually true, why wouldn't it be much more logical to warn all those who do not have ameba to avoid eating lettuce, so they might not become infested with this parasite?

Since Craig began some thirty, or forty years ago to call attention to the prevalence of ameba in the intestinal tract many surveys have been conducted and they invariably confirm Craig's work. Very often these surveys confine themselves to the presence of endameba histolytica only, and other form of amebiases are ignored. There probably is no harmless form of ameba. Of course the histolytica is the only form which goes beyond the mucous membrance of the intestines, and probably the only form which produces mortality. Never the less, the other forms are the cause of much morbidity, and many functional disturbances of the gastro-intestinal tract. So it has to be a fact that many people harbor ameba in one form or another in their intestinal tract without many, if any symptoms, although every one who does harbor this parasite is a potential ameba patient at some time during their life. In fact amebiases is found so frequently in symptomless people that it might be said that man and ameba live in symbiosis.

So admitting that the ameba is a common inhabitant of the intestinal tract of man, it might be well to speculate for a moment on the dissemination of this parasite. It is a well known fact biologically that ameba lives a very short time when it leaves the intestinal tract and looses the body temperature of its host. It is usually the encysted form which is transmitted. It is also known that the cyst is not resistant to

The Camoform used in this stuly was furnished by Park Davis Co., Detroit, Michigan.
The chemical name for Camoform is — Diallyl-diethylamino cresol dihydro-chloride.

extremes of heat or cold, and even drying out soon destroys it. Getting back to the subject of lettuce, why blame the head of lettuce that happens to be exposed to human excrement out in the lettuce field? It is the soiled hand which has just served the lettuce at the dinner table which transmits the parasite from one host to another, and the same thing applies to the bread and butter, and even the soup which often is not hot, and is served with thumbs. Magath expressed it when he said, "the human race has not reached that point where the intestinal contents of one does not find its way into the stomach of another."

SYMPTOMATOLOGY

The treatment of chronic amebiases cannot be intelligently discussed without some reference or explanation of symptoms. The following positive statements offer strong suspicions of the presence of amebiases. 1. Ameba is the commonest cause of alternating attacks of constipation and diarrhea. 2. Ameba is a very common cause of chronic constipation. 3. Ameba is a common cause of headache. 4. When gallstones and peptic ulcer are excluded, ameba is the commonest cause of digestive disturbances. 5. Ameba is a frequent inhabitant of the intestinal tract in the so called irritable bowel syndrome. 6. Ameba is a very common cause of flatulent dyspepsia. 7. Ameba is the cause of many bizarre gastro-intestinal symptoms which might be attributed to disturbances of the autonomic nervous system. . Ameba is a common cause of a persistent leukopenia ranging between 4,500 to 6,000 leukocytes. 9. Ameba is probably the commonest cause of excessive mucus in the stools. However, whether it is the sole cause of so called mucus colitis where large amounts of mucus are eliminated from the bowels is equivocal, as this is one of the most intractable intestinal afflictions to alter with any form of treatment, including anti-amebic regimes. 10. There are a number of interesting observations in children, whose parents have amebiasis, especially if it is the mother who is afflicted. 11. The following triad of symptoms can frequently be observed in amebic patients; flatulent dyspepsia; bizarre, autonomic nervous system symptoms arising from the digestive tract; and mucous membrane irritation, not necessarily confined to the gastro-intestinal tract. 12. Many of these statements are certain to be controverted, but are conclusions arrived at after prolonged clinical observations of many patients who have followed anti-amebic treatment.

TREATMENT

The treatment of chronic amebiases is the control of symptoms and many of the symptoms are the result of functional disturbances. These functional disturbances have often been present for months and even years. For this reason a negative stool examination means very little in the relief of the average patients symptoms. Furthermore, pouring large amounts of anti-amebic drugs into these patients in short periods of time is more liable to aggravate these functional disturbances than to give any relief. As patients symptoms are relieved it is usually necessary to keep them on regimens which include small doses of anti-amebic drugs, either continuous or interrupted, for periods of weeks and months.

Since its introduction some three years ago, Camoform has been administered to sixty-four patients in whom a diagnosis of chronic amebiases was made. Of these sixty-four patients thirty-six were new patients who had had no treatment previous, and twenty-eight were old patients who had had treatment with the older anti-amebic drugs. Of the thirty-six new patients, twenty-three responded satisfactorily to treatment. Six patients were unimproved and the Camoform was discontinued. In the other seven patients the treatment was stopped because it aggravated the existing abdominal symptoms. These were mostly patients of the irritable colon syndrome variety. In the twenty-eight old patients who had been on other forms of medication, five seemed to do better on Camoform than any of the older drugs. In twelve cases the response was about the same as on the previous regimens. Eleven cases were unimproved, and in some of these, especially the irritable colon variety, the old symptoms were aggravated.

In the entire group of sixty-four patients treated with Camoform there has not been a single case of dermatitis. No doubt this has been due to the low dosage. The average dose of Camoform received by these patients was .25 gm. once daily. Twenty of the new patients whose symptoms were quite acute and who were of the robust type, and without much irritability of the colon, were given .25 mg. twice a

day. Usually after a month of treatment it was reduced to .25 mg. once a day. This dosage has been continued by most of these patients, for interrupted periods, for one to two years. Three of them have taken .25 mg. once daily continuously for over a year without untoward bad affects.

In speaking of patients with acute symptoms it is probably impossible to determine whether the patient is suffering from acute amebiases, or an acute exaccerbation of the chronic disease. It is much more likely to be the latter.

Under the present sanitary conditions in our nation where water and milk supplies are so well regulated it is probably quite rare where any one is exposed to large numbers of ameba in a short period of time, as for example the Chicago epidemic in 1933. If we were actually in search of acute amebiases we would probably have to look to children or young infants. Acute amebic dysentery has been reported in a two week old baby whose mother was found to have a positive stool examination.

Most patients suffering from chronic amebiases should receive emetine hydrochlorid, and the average dose is one-half grain once a week given over periods of eight to twelve weeks, and repeated after intervals of four weeks or more. When dysentery occurs in chronic amebiasis, the oxyquinolines are more liable to give the most relief.

The judicious use of the anti-biotics in all cases of amebiases along with the anti-ameba therapy (this statement is not intended to include those anti-biotics which are supposed to be specific for ameba) much enhances the possibility of satisfactory clinical results.

CONCLUSIONS

1. Chronic amebiases is a controversial subject and will continue to be until its prevalence is more generally recognized.

2. If one depends on demonstrating the presence of ameba in routine stool examination in private office practice many cases of amebiasis will be missed.

3. There probably is no such thing as a harmless ameba, although many human beings may harbor their presence in the intestinal tract for years without apparent symptoms. But every one who does harbor them is a potential amebic patient at some time.

4. When ameba is suspected, and it is not demonstrated in the stools, a therapeutic test is indicated.

5. The only way to accurately determine the effects of anti-amebic drugs, in chronic amebiases, is close clinical observance of the response to the control of symptoms.

6. After observing the response to treatment in these six-four patients over a period up to three years Camoform has demonstrated its therapeutic affect and takes its place among the other anti-amebic drugs at our disposal.

7. Camoform is especially advantageous in the treatment of chronic amebiases as it can be given in small dosage over long periods of time without untoward symptoms.

THE DIAGNOSIS AND TREATMENT OF THYROID CANCER

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WHILE some aspects of the management of thyroid cancer are controversial, there are many areas of the subject in which there is complete agreement. It is generally conceded, for example, that the diagnosis of thyroid cancer can be established and excluded only by histological examination of the tissue. There is also no doubt that the definitive treatment of thyroid cancer is the surgical excision of all removable cancerous tissue. I shall not elaborate on these accepted principles. However, how radical the surgical procedure should be and the role of conventional radio-therapy are debatable. Furthermore, the value of the radioactive isotope, I-131 in the clinical management of suspected or proven cancer is of great interest. In about 15% of cases it plays an active role in treatment. I shall discuss, particularly, the use of these modalities.

INCIDENCE:

Thyroid cancers are not rare and form roughly 1% of all cancers. They may occur at any age. They are not uncommon in children but the usual occurence is between 40 and 60 years of age. They occur more frequently in women. Some have thought that 90% arise from originally benign adenomas (1) but this is doubted by others (2) since an encapsulated nodule usually is either wholly benign or wholly malignant throughout.

PATHOLOGY:

The simplest classification is that of Foot (3) who distinguishes three groups, malignant adenoma, papillary adenocarcinoma and other carcinomas. However, these categories overlap. In non-goiterous regions, the papillary types prevail; in goiterous areas, the non-papillary types.

Malignant adenomas are of low or potential malignancy and formerly comprised the largest group of thyroid cancers but their incidence is decreasing. The benign tumors are classified into simple adenomas and cyst-adenoma. They are considered malignant when there is evidence of blood vessel invasion or invasion of the capsule. The adenomas which are of the fetal or embryonal type are more likely to show blood vessel invasion but the evaluation of this finding is sometimes difficult even for an experienced pathologist. A characteristic of the tumor is vascularity of the stroma. The close proximity of the malignant cells to the vessels, which often are sinusoids, predisposes to early invasion. At the same time, as has been emphasized by Portmann (4), errors are often made when based on histology alone. The term "benign metastasizing thyroid" originated in this way and refers to a well-differentiated benign-looking tumor with metastases already present.

At least 60% of the cancers are papillary adenocarcinomas. It is a relatively avascular type and is likely to be encapsulated. Blood stream invasion is not common and spread usually occurs by the lymphatics. Local recurrence after operation is common. Many tumors have been thought to arise from lateral aberrant thyroids but it is more generally agreed that these are metastatic implants rather than primary tumors. (5) The tumors found in young people are most often of this type.

Other carcinomas of the thyroid form the smallest group. Ordinarily, they bear no evident relation to previous thyroid disease. They occur in older patients, invade locally and show no striking tendency to spread by the blood stream. In general, these tumors are much like cancer elsewhere and show no particular reference to the thyroid as a functioning gland, although some alveolar carcinomas take up iodine. (6)

METASTATIC SPREAD:

The spread of the adenoma and cystadenoma by blood vessel invasion and of papillary adenocarcinoma through regional metastases may be very slow. It is not unusual for these tumors to recur after several years or for metastases to remain apparently docile in nodes, bones or lungs for five years. A recent case which I observed was subjected to thyroidectomy in 1922. Pulmonary metastases did not appear until 1946. Death occurred in 1951, but from an unrelated cerebral hemorrhage. Unilateral tu-

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mors usually are associated with unilateral node involvement. The nodes along the larynx, trachea and external jugular vein are commonly invaded.

There is a striking tendency for thyroid tumors to metastasize to bone. They usually appear in the spongy portions of the bone, are richly vascularized and may pulsate. Lung metastases are apt to be multiple and often are subpleural (5).

FUNCTION IN RELATION TO HISTOLOGIC STRUCTURE:

From the point of view of the present discussion our interest in the histologic structure is in relation to sensitivity to radiation and iodine uptake. It has long been known that contrary to experience with most tumors of other origin, thyroid cancers which are well differentiated and apparently functioning are most likely to be radiosensitive. Rawson and Starr (7) from their studies concluded that **cell height** is a good index of thyroid activity. Increase in cell height denoted cellular hypertrophy, and hypertrophy was an accompaniment of hypersecretion. Bobyns, Skanse and Maloof (8) emphasize that **relative uniformity in cell height** is a characteristic of normal and non-neoplastic hyperplasia. Increasing variability in cell height marks the transition to neoplastic tissue but secreting neoplastic tissue cells vary less in height than those of non-secreting type.

Rawson and Trumbell (9) prepared a classification of benign and malignant tumors relating histologic structure to funtion, but the groupings are not rigid. In general, cancer is less apt to take up iodine than normal thyroid tissue. There seems to be a correlation between the presence of follicles and the ability to concntrate iodine. Nevertheless, Beierwaltes (6) reports that of 32 cancerous thyroids that responded "favorably" to treatment with I-131, sixteen had follicular, ten alveolar and six had papillary carcinoma. Evidently the final practical test of the possible efficacy of I-131 is uptake and distribution, not histology.

I-131 UPTAKE IN RELATION TO THYROID CANCER

It has long been recognized that thyroid cancer is not often found in association with clinical hyperthyroidism; a few malignant adenomas are the exception. Furthermore, while cancer may develop in a toxic adenoma, this is unusual (8). In an occasional case, a malignant nodule has been found in the midst of a hyperplastic gland removed for hyperthyroidism and occasionally, a nodule on one side is functioning, another on the other side is non-functioning and malignant.

I-131 technics have demonstrated that cancer generally takes up less iodine than other thyroid tissue. If then a nodule is found that takes up iodine briskly—this is usually called a "hot" nodule—the chances are that it is not malignant but it must be re-emphasized that the presence or absence of mild toxicity should not **per se** establish the definitive diagnosis. On the other hand, a single "cold" nodule should arouse a considerable suspicion of malignancy. It is found that 18% of all single thyroid nodules are cancerous (8) which is a much higher incidence of malignancy than occurs in multiple nodular goiter. Nodules are not always sharply "hot" or "cold" and those that are "lukewarm" present difficult problems in evaluation. However, the study is recommended not primarily with the thought of diagnosis but to determine management and since I-131 uptake studies put no strain on the patient, and single nodules are relatively easy to scan directionally, there is no reason for withholding the tests. Certainly a functioning nodule that continues to be "hot" even though it increases in size, will be of less concern than a "cold" nodule under similar circumstances.

The work of Corrigan and Hayden (10) suggests that the presence of cancer introduces a qualitative change in iodine metabolism with a prolonged high activity in the liver. They noted a diminishing activity in the tumor tissue compared to a maintained level in the normal tissue. In our limited experience this has not been confirmed.

It has seemed to us that I-131 studies are an essential procedure in the pre-operative study of all patients who are to be subjected to thyroid surgery. The proper treatment of a known cancer undoubtedly requires knowledge of its function. However, many thyroid cancers are unsuspected, and the diagnosis is made only when the pathologist studies the specimen. Therefore, not only all patients with cancer and toxic goiter but all goiters except possibly the multiple nodular variety should receive a pre-operative determination of the

I-131 uptake. In addition, it is desirable to make radioautographs of the excised tissue.

THE TREATMENT OF THYROID CANCER:

The definitive treatment of thyroid cancer, whether or not there are metastases, regional or distant, is removal of all cancer tissue. Whether the surgery needs to go beyond excision of the recognized tumorous tissue is debatable and is beyond the scope of the present discussion. However, in my opinion radiation, both pre- and post-operative, if carried out intelligently and skillfully, can widen the scope of surgery and improves its results.

According to Cade (11) the rationale of **preoperative radiation** depends on:

1) The danger of blood stream spread during surgery because of the intimate relation of tumor cells to blood vessels particularly in the malignant adenoma.
2) The survival of radiated cells that are spread is not as likely.
3) The dosage to achieve this effect is moderate (2000-3000 r). It results in little damage to normal tissues and does not delay operation unduly.

However, the therapist is seldom given the opportunity to apply this treatment and further discussion is not warranted at this time. Therefore our main interest is in post-operative radiation which is advocated not as a prophylactic procedure but as an integral part of the management of the patient. In Cade's opinion, it is mandatory (1) where the operation is difficult due to the extent of the growth (2) where extracapsular extension is present (3) where cervical nodes are involved and (4) in the presence of non-removable recurrence. Hare and Salzman (2) present statistical evidence to support the thesis that all but fetal adenoma should receive routine post operative therapy. Many thyroid cancers are responsive to x-ray therapy and this can be determined in the individual case only by trial. On the other hand patients will survive with surgery alone. My own feeling is that radiation should be given on an individual basis depending on the presumed adequacy of the surgical removal. I am convinced that radiation can control some residual tumors. A dose of 4800 r to the tumor bed in 21 days is recommended by some while others use smaller doses of the order of 3600 r. Implantation of radon seeds may be desirable in certain situations, particularly in recurrences.

Contrary to some surgical opinions, Rawson and Trunnell (9) contend that all normal thyroid tissue should be removed as part of the primary surgery of thyroid cancer. If a partial thyroidectomy has been performed either electively because the tumor seemed circumscribed, or because the cancer was unsuspected and found only after histological examination, many feel that the remainder of the normal thyroid should be removed at a second operation or medically by the therapeutic use of I-131. The rationale for this attitude is that if metastases are present or appear in the future, definitive treatment, if it is to depend upon I-131 uptake, will require the elimination of normal thyroid tissue. Thyroidectomy as an integral part of the first approach makes the systemic and repeated search for functioning local recurrence or metastases a much simpler task. There is considerable merit in this approach and it should be used more often than is customary. The problem is in which case to use it and this is a matter of clinical judgment. The fact that because of the thyroidectomy, the patient will require thyroid medication for the rest of his or her life does not seem radical as against the early diagnosis of recurrence or spread. Only functioning metastases can hope to be controlled with I-131 and even conventional radiotherapy is more likely to be effective under these circumstances. One does not refer to "cure" because even in apparently favorable cases an uneven distribution of the isotope may be insurmountable.

When metastases already are present total removal of all thyroid tissue either surgically or by I-131 is essential. It is hoped that this will put a demand for hormone on otherwise non-functioning cancer cells. It is known that in some cases these cells may begin to function although this may not occur for two months, or even as Rawson has reported in some cases, two years. Since the metastases are often not rapidly progressive, there is justification for continued effort over a long period of time. Thyrotropic stimulating hormone (TSH) may stimulate the iodine-concentrating capacity of certain thyroid cancers. TSH (Armour) given in doses of 30 mg per day for four to eight days has been reportedly effective in some cases. However, more commonly, thiouracil in large doses has been used. Rawson (9) recommends

that two months and perhaps sooner after surgery, 1-2 grams per day is given for weeks or months. At the end of each month, and about 96 hours after discontinuing the drug, a tracer of I-131 is given. Precisely when treatment may be worthwhile is difficult to establish and depends on clinical judgment. One rule is when the 24 hr. urinary I-131 is less than 25% of the oral dose and provided the blood I-131 is less than 1% per liter of whole blood, 48 hours after the test dose. Another is when the uptake exceeds 10%. It may be desirable to follow thiouracil with a course of TSH or give the two drugs simultaneously. Thiouracil probably acts through augmenting the effect of TSH in localizing the isotope in cancerous tissue. A recent alternative suggestion is to suppress endogenous TSH hormone production by giving large doses of thyroid hormone (13).

The actual dosage of I-131 to be used also is largely empiric. Total cumulative doses between 100 and 1000 mc have been used. Ordinarily between 50-100 mc are given in a single dose depending on the uptake and the estimated size of the tumor. I-131 delivers about 158 rep per microcurie per gram of tissue assuming homogeneous distribution. If allowances are made for spotty distribution and biologic half life, one might aim at about 48,000 r or 300 uc/gram of tissue. However, in practice, the estimate of amount of tumor tissue often is quite erroneous and only empiric doses are useful. In general, only one metastasis at a time collects damaging amounts. After its regression, another deposit assumes the role of a "major collector." The toxic effects of large doses of I-131 are not ordinarily serious if blood I-131 levels are watched but may include (1) hyperthyroidism due to rapid breakdown of thyroid tissue and the release of thyroglobulin (2) amenorrhea (3) depression of blood elements with a diminution in the number of lymphocytes which is followed by a depression in the number of platelets.

SUMMARY:

1) The diagnosis of thyroid cancer is established only by histological examination of tissue by an experienced pathologist.

2) The definitive treatment of thyroid cancer with or without distant metastases is the surgical removal of all cancerous tissue. There is merit in the recommendation that all normal thyroid tissue should be removed in many cases either at the primary surgery or subsequently by the therapeutic use of I-131. Certainly all cases to be treated with I-131 should be so treated.

3) In a general way, the histological appearance of the cancer can be correlated with functioning capacity. In general the more differentiated the cells and the more uniform the cell heights, the more likely the tumor is to function. However, in the individual case, no tumor should be assumed to take up I-131 or the possibility excluded by the histology alone.

4) Radiation therapy should be an integral part of the planned attack on thyroid cancers and is advised at least in cases where complete surgical removal is not possible. Post-operative conventional radiotherapy to the tumor bed is recommended in all cases of thyroid cancer depending on the presumed completeness of the surgical excision.

5) Known cancers should be studied preoperatively with respect to I-131 uptake, and radioautographs should be made of excised tissue. Because cancer is often found unexpectedly, much can be said for performing these tests prior to removal of all nodular goiters except possibly a non-toxic multiple nodular goiter.

6) The treatment of functioning metastases is by large doses of I-131. Various methods may be used to improve the uptake when it is otherwise too low. While cure will probably not take place, prolonged satisfactory life may be the reward for painstaking effort. The treatment of non-functioning metastases may not be rewarding but conventional radiotherapy is always worth a trial.

1. Selye H., Endocrinology, Univ. of Montreal, Canada, 1948.
2. Pemberton J. de J. and Black, B. M., Cancer of the Thyroid, Amer. Cancer Soc., N. Y., 1954.
3. Foot, N. C., Pathology in Surgery. J. P. Lippincott Co., Phila., 1945.
4. Portmann, U. V., Amer. J. Roentg. 32. 508, 1940.
5. Ackerman, L. V. and Del Regato, J. A., Cancer. C. F. Mosby Co., St. Louis, 1947.
6. Beierwaltes, W. H., Handbook of Nuclear Techniques. Nucleonics, N.Y., 1954, Page 115.
7. Rawson, R. W. and Starr, P., Arch. Int. Med., 61. 726. 1938.
8. Means, J. H., Lectures on the Thyroid. Harvard Univ. Press., Cambridge, 1954.
9. Rawson, R. W. and Trunnell, J. B., In Radioisotope Therapy. Edited by P. F. Hahn. Academic Press, N. Y., 1951.
10. Corrigan, K. E. and Hayden, H. S., Radiology. 59. 1. 1952.
11. Cade, S., Malignant Disease. Williams and Wilkins. Baltimore, 1949.
12. Hare, H. F., and Salzman, F. A., In Clinical Therapeutic Radiology. Edited by U. V. Portmann. Thos. Nelson & Son, N.Y., 1950.
13. Catz, B., and Starr, P., U. S. C. Med. Bull., 7. 17. 1955.

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DANGERS OF DELAYING SPEECH THERAPY

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THE general delay in seeking treatment of speech disorders is disturbing to the speech pathologist. Exclusive of adults, those coming to the writer's ofice for speech therapy during the last fifteen years have averaged seven years, plus.

An individual learns more from birth to age six than during any other six year period. High impressionability and a naturally avid curiosity during this period enable him to sap up a vast quantity of learning—including speech. It is the natural thing for the individual to have developed near-normal speech, without assistance, by age five. And it is easier for the speech defective to achieve normal speech, with assistance, during this natural speech development period of under six.

This is not only true because of natural learning ability, but further true because defective speech habits become progressively more deeply rooted from age five on. And by the same token, they become progressively more difficult to correct. A case in point concerns two brothers, one four and the other six. The four-year-old was near alalic and the six-year-old severely dyslalic. Response of the younger child to speech therapy was amazingly faster than that of the older. Almost without exception, the speech sounds commonly defective in the two brothers were more quickly corrected in the four-year-old, and it was a relatively short time before the younger child achieved more intelligible speech than the older one.

Further demonstrating the wisdom of early treatment of speech disorders is the fact that a great majority of stutterers six years and under can be corrected in six months, while those over six require eight to ten months. And severe dyslalias, in which speech is quantitatively normal but qualitatively unintelligible, usually can be corrected in twelve months if therapy is begun in four- to five-year-olds, but they require a minimum of eighteen months if therapy is delayed beyond age six.

An added reason for early treatment of disordered speech is the danger of psychological trauma. Abnormal speech presents a glaring deviation from normalcy. And a speech disorder reaches its peak of seriousness when the child conceives the idea that he is an abnormal individual. The time of such a conception varies with the individual, but three-year-olds have been known to be so embarrassed by a speech inadequacy that they refused to talk at all. At the other age extreme, a seventeen-year-old shed tears following an examination and discussion of his speech failure—and his mother shed tears over what she termed her neglect for assuming over the years that her son would outgrow the disorder.

If the child is fortunate enough not to recognize his defective speech as a handicap during the preschool period, he usually is quick to recognize it as such upon entering school. Children strange to him are quick to point out his deficiency since they are brutally frank in pointing out abnormal deviations in others, and their fun-poking, mimicry and slighting remarks spotlight the speech defective as abnormal, queer, "crazy." And thus is sown the seed for personality trauma which will persist long after disordered speech has been eliminated.

Since speech disorders are more easily corrected at an earlier age than when treatment is usually sought, and since allowing them to go untreated is a hazard to personality, the question arises, why do parents delay in seeking treatment? The answer is that nearly every parent believes his child will "outgrow" the speech failure. This attitude constitutes the greatest problem the speech defective faces in securing relief from his handicap. Not only does such a trust exist among parents, but this trust is strengthened by advice from friends, neighbors, relatives and other associates. Typical is the case of a child whose mother brought her for speech examination and who, subsequently, was started on a therapeutic program. After several treatments, however, it was reported that the father had decided against further treatment. He had been convinced by "the men at the shop" that the child would outgrow the difficulty.

*Speech Pathologist.
Editors note: This is the first of a series of articles by Dr. Plummer dealing with speech disorders. Others will follow in future issues of Arizona Medicine.

While it is true that some do outgrow defective speech, the assumption that all children will do so is proven false every day in the speech pathologist's office. Here one sees individuals nineteen years and down whose speech is barely intelligible. One sees stutterers ranging from adults downward, and he sees accompanying parents with abnormal speech characteristics which obviously were not outgrown. Sometime ago a mother brought her five-year-old for speech examination, but decided to give the child another chance to make spontaneous recovery. Two years later the child was returned for re-examination which revealed almost identical severity of speech deficiency as noted in the first examination. Another child, a stutterer aged seven, was brought for examination, and in this case too it was decided to delay treatment. This child was brought back nine years later—now a high school student—with a more severe and deeply rooted stutter than when originally examined.

More specific information concerning the number of children who do not outgrow speech failures is to be found in statistical records. Extensive testing by the writer in twenty Phoenix elementary schools and in the Training School at Arizona State College, Tempe, revealed that 22 percent of all first graders in these schools had defective speech. It was also revealed that 18 percent of all eighth graders were defective; which is a relatively small decline over this period of eight years. And the decline from eighth grade on will be still smaller, since the older the individual the less the possibility of spontaneous recovery from defective speech.

What is the solution to the problem posed by a general apathy toward speech handicaps? The answer appears to be education. The parents, the schools and every agency which contacts the speech defective must be alerted to the urgency of early treatment of speech disorders. The solution is not to play a waiting, wishful game to see which children will, and which ones will not,make a spontaneous recovery. Just as we immunize 100 per cent against all diseases in which it is possible to do so, so is it sensible to treat all speech disorders persisting beyond age five—or the age at which near-normal speech reasonably can be expected —in order to safeguard those who will not recover without assistance.

PHOENIX *Clinical* CLUB

The Case History in this discussion is selected from the Case Records of the Massachusetts General Hospital, and reprinted from the New England Journal of Medicine. The discussant under Differential Diagnosis is a member of the staff of the Massachusetts General Hospital. The other discussants are members of the Phoenix Clinical Club.

MASSACHUSETTS GENERAL HOSPITAL

PRESENTATION OF CASE 38452

A TWENTY-THREE-YEAR-OLD para III, gravida III, was admitted to the hospital because of right lower abdominal pain.

About nineteen months prior to entry the patient experienced for the first time a sharp, stabbing pain in the right lower quadrant that lasted twelve hours and was relieved by codeine. Since that time bouts of similar pain had occurred approximately every two or three months. On the morning of admission she noted the sudden onset of pain in the right lower quadrant described as a constant, deep ache with radiation into the right flank and down the right leg, which was not relieved by 3 codeine tablets. She vomited twice.

The patient had felt well until the beginning of the pain. She had had three full-term normal deliveries five, three and one-half, and two and one-half years before entry. Since the birth of her first child she had had a whitish vaginal discharge, which she thought had increased somewhat recently. She denied venereal infection. The menarche had occurred at thirteen years of age, and menses had occurred every twenty-eight to thirty days, lasting five days with a normal flow. Her last menstrual period ended seven days before admission to the hospital. There were no bowel or urinary-tract symptoms. She had been married six years but was separated from her husband from time to time because of his excessive drinking.

Physical examination showed a well developed woman in no acute distress. The heart and lungs were normal. Both lower quadrants were

tender, the right much more so than the left. There was slight rebound tenderness and no real spasm except on deep palpation. Peristalsis was normal, and there was a positive psoas sign on the right. On pelvic examination there was considerable whitish mucoid discharge in the vagina. There was exquisite tenderness on motion of the cervix, mainly on the right. The uterus was enlarged to about twice the normal size and was firm. There was severe tenderness in the right vault, and a firm, tender, rounded mass measuring 3 to 4 cm. in diameter. The left vault was slightly tender but free of masses. Rectal examination disclosed nothing further.

The temperature was 100°F., the pulse 95, and respirations 24. The blood pressure was 120 systolic, 70 diastolic.

The urine gave an X test for sugar; the sediment contained occasional white cells and red cells. Examination of the blood revealed a hemoglobin of 11 gm., and a white-cell count of 12,000, with 90 per cent neutrophils.

On the second hospital day examination revealed marked tenderness and spasm in the right lower quadrant but very little tenderness and spasm in the right lower quadrant but very little tenderness on motion of the cervix or in the right vault. During the next three days the pain varied in severity, and at times the patient felt anorexic but did not vomit. The right-sided mass continued to be tender but did not increase in size. The temperature and white-cell count remained slightly elevated despite the administration of 600,000 units of penicillin started on the third hospital day.

On the fifth hospital day an operation was performed.

Dr. Clarence B. Warrenburg

The diagnosis of the twenty-three year old female who was admitted to the hospital because of right lower abdominal pain, is twisted right ovarian cyst.

In the differential diagnosis of this interesting gynecological patient, chronic pelvic inflammatory disease must be ruled out, as well as ectopic pregnancy, and probably tuberculous salpingitis. The question of appendicitis is always present when there is right lower quadrant pain and tenderness, and in today's case it must be considered. In chronic pelvic inflammatory disease, almost invariably a history of an initial acute attack of pelvic inflammation can be obtained. As a rule the symptoms develop gradually, although at any time the clinical course of chronic pelvic inflammatory disease may be punctuated by acute exacerbations. The pain in chronic PID is usually deribed as a bearing down or aching discomfort in the lower abdomen and pelvic regions, however, sometimes it is described as sharp and severe. Rather characteristically the pain is exaggerated just before or during menstruation. In the early stages, the patient may complain of only discomfort, especially on exertion or prolonged standing. Later the pain is constant and severe. Backache is often a troublesome symptom, as is rectal discomfort or pressure explained by the fact that the diseased adnexa impinge upon the rectum to which they are not infrequently adherent. Dysmenorrhea is the most common of the menstrual symptoms and it may be so severe as to necessitate bed rest at each menstrual period. Menorrhagia is not uncommon though rarely excessive. Leukorrhea is almost always noted. Sterility is a prominent feature in PID.

More important than the history in chronic PID, is the physical examination and especially the bimanual palpation of the pelvic organs. This reveals in the typical case, an irregular, tender and rather fixed mass in both sides of the pelvis and sometimes filling the cul de sac. The uterus may be in normal position, but it is often retroverted, and often much less movable than normal. Efforts to move it about by manipulation of the cervix or fundus, usually causes much pain, and drawing the cervix forward will make the patient complain of pain, which not infrequently is referred to the rectum.

In ectopic pregnancy, there is likely to be a slight delay in menstruation, followed by persistent slight bleeding of a spotting character. In pelvic inflammatory disease and in twisted ovarian cyst, the menstrual rhythm is often not disturbed. With ectopic pregnancy, the pain is likely to be colicky, severe and one-sided, and frequently there is nausea and faintness. The latter is lacking in PID, but can be present in twisted ovarian cyst. Pelvic examination in cases of tubal pregnancy, show a unilateral tender mass with no tenderness in the opposite side, exactly as our case is described today. However, it is noted in this protocal, that there is no disturbance whatsoever of the menstrual rhythm. In PID, the condition is almost always bilateral.

A pyosalpinx may be mistaken for an adherent ovarian cyst or vice versa, and a similar difficulty may arise in differentiating a large hydrosalpinx from a small ovarian cyst. Usually, however, ovarian cysts are readily distinguishable by their rounded, smooth, elastic feel, and their free movability.

Pelvic endometriosis is another condition which may be difficult to distinguish from chronic pelvic inflammatory disease, and endometriosis of the ovary may be indistinguishable from ovarian cyst, or twisted ovarian cyst. In endometriosis, as in PID, there is a history of pelvic pain and increasing dysmenorrhea, disparunia, and involuntary sterility. In either, the pelvic examination reveal the adnexa to be enlarged, adherent to the posterior surface of a retro-placed uterus. The presence of one or more nodules in the utero-sacral ligaments, is always highly suggestive of endometriosis.

The symptoms of tuberculous salpingitis are much like chronic gonorrheal salpingitis, and the preoperative diagnosis usually cannot be made. However, there are certain features which will lead one to spect the nature of the lesion. The known existance of pulmonary or urinary tract tuberculosis, especially in advanced form, might give a clue in some cases, the demonstration of the tubercular bacillus in the discharge. The fact remains that in most cases, tuberculous salpingitis is not suspected before operation and that many of the patients are otherwise in good general health.

Torsion or twisting of the pedicle of an ovarian cyst and the acute symptoms thus precipitated are not infrequently the first indication of the presence of an ovarian tumor. This complication is more common with tumors of small or moderate size than with the very large ones. A number of factors may be concerned in the production of torsion, most important being the weight of the tumor, or trauma in the form of sudden jolts, and the peristaltic movement of the intestines.

Twisting of the pedicle is generally in a clockwise fashion, and it may be slight, or so extreme that several complete twists of the pedicle are demonstrable. The circulatory disturbance produced by the torsion usually effects the veins chiefly, with intense venous stasis so that the cyst becomes dark bluish or even black in color. In extreme cases, the arteries are also occluded with gangrene of the cyst as a result. The cyst may even, if the condition is not recognized or neglected, twist itself off completely and cases are recorded in which rather large cysts have thus been severed from their attachment and undergone complete absorption.

The occurence of torsion of the pedicle is associated with pain which may be sharp and persistent, but which in other cases may be only moderately severe and transitory. The latter is true when the twisting of the pedicle corrects itself as it not infrequently does. A history common in cases of ovarian cysts of moderate size, is that from time to time the patient has experienced attacks of sharp pain with spontaneous disappearance after a short while. Such attacks are quite certainly due to moderate and transitory twisting of the pedicle.

In a considerable proportion of cases, however, the symptoms produced by torsion of the pedicle are much more urgent. Sudden excruciating pain is experienced, usually referred quite definitely to one side or the other of the lower abdomen. When the cyst is on the right side, the simulation of acute appendicitis may be made all the more perfect by the occurence of nausea and vomiting and the development of tense rigidity over the right lower abdomen. The pulse is accelerated and the temperature elevated though it rarely rises more than perhaps 101. Examination of the blood shows a moderate leukocytosis. It is not surprising, therefore, that many patients with this condition are operated upon for the mistaken diagnosis of acute appendicitis.

Our patient today, fits so easily into the diagnosis of twisted right ovarian cyst that I wonder if we might not be in error. I still remember an early clinical club case that was given to me with the final diagnosis of normal uterus. I feel fairly sure that our patient does not have chronic pelvic inflammatory disease because in that condition, the pelvis is more fixed and more likely to be bilateral. The diagnosis of ectopic pregnancy does not gel because there is no menstrual irregularity whatsoever. The fact that the uterus described as twice its normal size, may very well be due to her multiparity. The exquisite tenderness in the right adnexa on manipulation of the cervix, which is so characteristic of ectopic pregnancy, can also be present with twisted ovarian cyst in precisely the same degree of tenderness. Endometriosis is also ruled

out because there is very little fixation of this pelvis. Patients with endometriosis of any degree are frequently sterile. This patient is anything but sterile. Her fertility also help rule out chronic pelvic inflammatory disease and tuberculosis of the tubes.

Appendicitis is ruled out because these recurrent attacks during the 19 month history of this condition would not be relieved in 12 hours if the diagnosis were recurrent appendicitis. Then the firm, tender, rounded mass, measuring 3-4 cm. in diameter in the right adnexa, is not characteristic of acute appendicitis. Our final diagnosis then, is the same as our original tentative diagnosis, namely, twisted ovarian cyst, right. It is not possible to diagnose the type of cyst preoperatively.

DIFFERENTIAL DIAGNOSIS

Dr. Howard Ulfelder: This young married woman of known fertility and good health came into the hospital with an acute illness of less than a day's duration. The illness was characterized by sudden, right-lower-quadrant, constant, unremitting, aching, deep pain, which was followed by vomiting. Whether the codeine taken to relieve the pain was responsible for the vomiting I do not know; nausea was not mentioned. This pain apparently radiated to the right flank and down the right leg, and examination in the hospital disclosed tenderness in the right lower quadrant. Spasm may or may not have been present; it was not an outstanding feature of the examination. The intestinal tract showed normal peristalsis. She had a positive psoas sign, which I assume to mean that when she was asked to try to flex her hip against a certain amount of resistance she had pain in the right lower quadrant. Other findings at the time of admission are the enlarged uterus, described as twice the normal size, with marked tenderness to the right of the uterus in the vault, and a space-filling, tender object 3 or 4 cm. in diameter. She had slight fever and moderate elevation in the white-cell count, with a definite increase in the percentage of neutrophils. She had some cells in the urinary sediment, both red and white, but not in great amount. The hemoglobin was a little lower than one would expect in a healthy young woman but not enough so to suggest an acute massive hemorrhage as the cause of admission.

The differential diagnosis in a situation of this sort, I should think, include infection, interference with blood supply to some organ in this area, hemorrhage into an organ and obstruction to some smooth-muscle viscus. The localizing findings in this patient point to the right iliac fossa and the true pelvis. The radiation of the pain to the flank and down the leg, the positive psoas sign and the tenderness on abdomial pressure point to the right iliac fossa; however, the tender mass was in the true pelvis, which is not the right iliac fossa—although they are adjacent.

There are structures in the right iliac fossa—the right ureter and the cecum—that can be examined by the roentgenologist. I suspect that there were no abdominal or pelvic x-ray films, but I hope there were either pyelograms or a barium-enema examination.

Dr. Benjamin Castleman: No x-ray films at all were taken.

Dr. Ulfelder: In that case I cannot exclude a lesion in that area on the basis of the x-ray findings as I had hoped.

Other leads that I must explore include the history of previous attacks of pain in the same location that lasted approximately twelve hours —apparently she had at least four (enough to be significant), occurring without known provocation and so far as I can tell subsiding spontaneously. The history makes pregnancy unlikely. She had a normal menstrual history, she was known to have been fertile previously, and she had a period that was not described as having been abnormal in any way and ended seven days before admission. I assume that this pain started about midcycle for this patient. Whether this means that ovulation played any part in this picture I am not yet prepared to say. Endometriosis I should consider unlikely on the basis of the history. She did not have the characteristic dysmenorrhea, and she had three pregnancies, all within the previous five years.

Her course in the hospital is the next aid in arriving at a diagnosis. I assume, from the description that the diagnosis at the time of admission was deferred, that she was not considered to be desperately ill and that a program of supportive therapy was therefore instituted in the hope that a definite diagnosis could be arrived at under observation. One assumes from the history that on the supportive therapy she neither grew worse nor improved. One important feature of this early period of obser-

vation is confirmation of the finding of the mass in the pelvis. I am sure that when she first came in she was much too tender for any examiner to be absolutely certain that a mass was present. Over the course of the next few days the tenderness became somewhat less pronounced, and the presence of the mass was confirmed. One gathers that chemotherapy made little difference, and, therefore, after a short period during which it was hoped that chemotherapy would bring about some dramatic improvement, the surgeons decided to operate on her.

Whether at the time of exploration a more definite diagnosis had been made, I cannot tell from the record. No studies made while the patient was in the hospital under observation are of any particular help to me. There are some significant omissions from the protocol if they are really omissions. In the first place, a fasting blood sugar was not reported. That means to me that the physicians were not particularly impressed with the finding in the urine. Again, a Gram stain on the secretion from the vagina and cervix was not reported. The question of an acute pyosalpingitis of gonococcal origin would have prompted most physicians to make that Gram stain although it is not particularly significant unless it is positive. Thirdly, an Aschheim-Zondek test was not reported. The persistent presence of a mass in the right vault and the notation that the uterus was twice the normal size at the sime of admission, regardless of the menstrual history should have prompted an Aschheim - Zondek test. The lack of x-ray films I consider a significant omission also.

Dr. Castleman: A culture of the vaginal discharge showed abundant growth of Staphylococcus aureus and was negative for gonococcus. An Aschheim-Zondek test was negative.

Dr. Ulfelder: What is the differential diagnosis in this patient? First of all, she could have had an acute suppurative salpingitis, so-called pelvic inflammatory disease, which would explain the picture about as well as any other single lesion. However, an acute appendicitis with abscess, the appendix lying over the brim and partly in the true pelvis, could also explain it. A third possibility is an acute accident to the right ovary or to a cystic right ovary. This acute accident could have been thrombosis or hemorrhage into the cyst. Somewhat less likely conditions—because they do not explain all the findings—include a lesion of the right ureter, particularly a calculus, which could have caused a god many of the symptoms but would not explain the pelvic findings, or a lesion of the small bowel. This history is not unusual in patients with intussusception that does not completely obstruct. A Meckel diverticulum or some other lesion of the small bowel that produced intussusception could cause abdominal pain in the period before a small-bowel obstruction developed. There may be quite a long interval from the time intussusception begins in the small bowel to the complete occlusion of the involved loop.

My problem is whether to try to make on lesion explain the entire picture or whether to assume that the mass felt in the right vault was more or less an incidental finding but so adjacent to be the chief difficulty. Needless to say, I have not arrived at a diagnosis in my own mind. I had hoped that the x-ray films would exclude some of the possibilities for me, although I did not expect that they would actually make the diagnosis.

I have excluded endometriosis and tubal pregnancy by history. I have excluded a ureteral calculus, which would not explain the mass. I have not excluded an acute appendicitis although the history of onset and the course in the hospital are not consistent, but if there is one thing that is consistent about acute appendicitis it is its inconsistency as far as its behavior is concerned. I do not believe it was torsion of a right ovary, for then I should expect the mass to have become more tender and to have increased in size during the period of observation in the hospital. I am left, therefore, with the possibility of an acute appendicitis with abscess, which I shall put lowest on my list, the possibility of some lesion of the small bowel and finally, what I consider the most likely diagnosis, an acute supporative salpingitis—that is, pelvic inflammatory disease.

Dr. Walter Bauer: What do you think of hemorrhage into the cyst?

Dr. Ulfelder: I should expect that such a mass would get larger and more tender during the time of observation. Patients with such vascular accidents usually have a much higher white-cell count and less fever at the time of onset.

Dr. John T. Quinby: Do you think the diag-

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nosis of acute salpingitis is consistent with the history of episodes of right-lower-quadrant pain in the past?

Dr. Ulfelder: I think pelvic inflammatory disease, diverticulum, a cyst of the right ovary that twisted and untwisted or almost any of the diagnoses that I have raised could have have not let it influence me one way or the other.

Dr. Castleman: Under anesthesia, the surgeon examined the patient before operation and felt a large cyst, which lay in the midline, was movable and measured about 12 by 10 cm., and higher in the right vault another harder mass, which measured about 5 cm. in diameter. Do you wish to comment about that?

Dr. Ulfelder: That the patient was under anesthesia does not make the examination more accurate than the initial examination. The examiner may be badly fooled even when the patient is well relaxed. It does not help me to make a more accurate diagnosis from the list of my differential diagnoses. I assume that the larger cystic mass was what was previously called the two-times-enlarged uterus and the other was the tender mass found during the patient's preoperative course.

CLINICAL DIAGNOSIS

Right tubal abscess.

Twisted cyst with tubal abscess.

Twisted ovarian cyst (after ether examination).

DR. ULFELDER'S DIAGNOSIS

Acute suppurative salpingitis.

ANATOMICAL DIAGNOSIS

Paraovarian cyst, with twisted pedicle

Infarcted right ovary.

PATHOLOGICAL DISCUSSION

Dr. Castleman: At operation, the large midline mass proved to be a hemorrhagic paraovarian cyst, which had twisted about 360° counter-clockwise and had also twisted the right ovary along with it. The small hard mass was the infarcted right ovary secondary to the twist of the large paraovarian cyst. The tube itself had some hemorrhage into it, but there was no evidence of previous infection. The whole mass was removed en bloc, I suppose there had been some twisting and untwisting over the past nineteen months.

A PHYSICIAN: How large was the paraovarian cyst?

Dr. Castleman: Twelve by 8 by 8 cm; it was good sized, which is not at all uncommon. Often, a large noninfarcted paraovarian cyst is removed with a preoperative diagnosis of ovarian cyst, and a normal ovary is found beside it.

TREAT YOURSELF TO A WEEK OR TWO IN HAWAII IN THE SPRINGTIME, WHY DON'T YOU?

That's an invitation it's a pleasure to pass along. It comes from the Hawaii Medical Association, whose members are celebrating their organization's Hundredth Anniversary this coming April 22 to 29 in proper "Hawaii" as well as medical fashion. There will be a short but worth-while professional program on Monday and Tuesday mornings, a spectacular Centennial Celebration Pageant Tuesday night, and a traditional *luau* (Hawaiian feast to you Easterners) Tuesday night, with Polynesian entertainment.

This is the best time of the year to visit America's island paradise — clear, balmy days and cool, refreshing nights; spring flowers in profusion on the ground and in the trees; lovely island m— but you have the idea now, surely. Hawaii in the spring is always the greatest, and this is your chance to tie it into a professional meeting. It follows the American College of Physicians' session in Los Angeles, too. Write the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii, for reservations application forms.

CALIFORNIA MEDICAL ASSOCIATION

Committee on Postgraduate Activities
The 1956 Regional
Medical and Surgical Institute

Institute for Southern Counties Region — Laguna Beach — January 19-20

Institute for North Coast Counties Region — Santa Rosa — April 5-6

Institute for West Coast Counties Region — Carmel — March 1-2

Institute for San Joaquin Valley Counties Region — Fresno — May 10-11

Institute for Sacramento Valley Counties Region — Cal-Neva, Lake Tahoe in June

(exact dates to be announced later)

THE *President's* PAGE

AMERICAN MEDICAL EDUCATION FOUNDATION & HOUSE BILL 7225

THIS page will be devoted to two important items. The first, the AMEF of which everyone is familiar, has received very little contribution from the State of Arizona. You may remember in the 1954 House of Delegates, an assessment was made to cover our contribution to the AMEF and the Western Pact for Higher Education, but in 1955, the House of Delegates took no action on their committee recommendations. In other words, Arizona has fallen from a very high place in contributors to an amount that is practically nil. It is advisable that if you have made contributions to your school, or plan to make them, that they should be made to the AMEF and earmarked for your school. There are no deductions for handling and the total amount will go to your Alma Mater. Let me stress this again, that any contributions that you may make, should go through the AMEF tabbed for your school of your choice. Your Council at its meeting in November allocated $5.00 per member from the general fund to be utilized for the purposes of the AMEF and the Western Pact bringing our contribution of the State for its doctors, to approximately $3,500.00. This is Arizona's way of participating in a program to prevent government intervention into our medical school system.

The next item of very great importance, is House Bill 7225. You have heard of this frequently in my letters, in the AMA Journal and through our AMA President, Dr. Elmer Hess. His letter which will reach every member brings an important message and some of his points are as follows:

1. "This measure (House Bill 7225) would be a significant step toward converting Old Age and Survivors benefit system into a medical care program. It is the most subtle . . . and hence the most dangerous . . . approach yet devised."

2. "It was rushed through the House and will be considered by the Senate when it reconvenes in January and after hearings are scheduled by the Senate Finance Committee."

3. "The passage of this bill would carry with it dangerous implications for physicians and eventually tax burdens so heavy that our national economy might be threatened."

4. "AMA hopes to join with many other groups and individuals in a nationwide program of thoughtful Americans who believe in promoting sound economic security."

Dr. Hess has asked the physicians for constructive suggestions, and adds: "I want your participation as physician, as friend, as supportor. You can help by writing to your Senators, distributing the enclosed message to your friends and by making copies of it available in your reception room."

Both of these items, The American Medical Education Foundation and House Bill 7225 deserve the attention of all members of our association.

Harry E. Thompson, M.D.
President, Arizona
Medical Association

Editorial

ARIZONA MEDICINE
Journal of
ARIZONA MEDICAL ASSOCIATION, INC.

VOL. 13 JANUARY, 1956 NO. 1

MEDICAL DOCTORS AND "FAITH HEALERS

PRACTICALLY every physician at some time or other has recited to him the case of some one or other who has been miraculously healed by some "faith healer" who is making his appearance in the community. This is often someone who has "been given up by the doctors" or someone who has been treated by many doctors for many years and "they have not seemed to be able to find what the trouble was." The story of the "miraculous healing" is often flung at the physician with the implied challenge to explain it if you can and often times there seems to be the implication that physicians have too high opinion of themselves and are really quite impotent in their capacity for caring for the sick and sometimes there is the further implication that the physician is defrauding the public in pretending to be able to do so.

This is not to deny the occurrence of miracles nor is it to deny that physicians are infallible. Most physicians in our acquaintance would be quick to admit the existence and performance of miracles in the healings which they see occurring day by day in the marvelous working of the laws of nature and the powers of nature set into being and motion by the Omnipotent Supreme Being whom we worship. Miraculous cures, then, are nothing new to the average physician. It is his contention that they are no less miraculous by having occurred through the working of these God given natural laws than if they were done through the Apostolic gift of miraculous healing which "faith healers" claim to have. Also, most physicians of our acquaintance would be the first to admit their own weaknesses and fallibility and share the spirit of Ambrose Pare the French surgeon who is reputed to have said that he dressed the wounds but the Lord healed them.

Apropos of this subject our attention has been called to an article which appeared in the September 19th issue of the Presbyterian Outlook entitled "What About the Faith Healers?". The author of this article quotes freely from a small booklet prepared by Carroll R. Stegall, Jr., pastor of the Pryor Street Presbyterian Church in Atlanta, Georgia. Judging from the quotations from the booklet, Rev. Stegall is a little more than dubious concerning the sincerity of some of these so-called "faith healers" and of the genuineness of their publicized results, while at the same time he apparently does believe in the power of prayer in opening the way to healing. One quotation from this little booklet, we feel, will be of particular interest to our readers in Arizona and particularly in the Phoenix area.

"Healers go to any length to procure (testimonies). They will quote medical sources, true or false. In his March, 1952, issue of Healing Waters, Oral Roberts printed a cover picture which showed three men, the caption reading "Three Great Medical Doctors Congratulate Oral Roberts for His Ministry of Faith to Suffering

Humanity During the Roberts Campaign in Phoenix." The names of the doctors are given, and another photograph in the magazine shows Dr. J. H. Miller, outstanding medical doctor, president of a medical society of over 20,000 physicians . . .'

"Dr. Donald Grey Barnhouse, the nationally known pastor of the Tenth Presbyterian Church in Philadelphia . . . took the time to do a little research into these 'doctors.' An inquiry to the American Medical Association brought the answer from their Bureau of Investigation that not one of the men mentioned in the captions could be identified as doctors of medicine or licensed to practice medicine in Arizona. One of the three men was tracked down through a telephone directory in Phoenix, and was found to be operating as a "naturopathic physician' . . . No organization headed by Dr. Miller was discovered, and the 'North Towne Clinic' supposedly operated by one of the men was non-existent. Yet this 'man of God' has the temerity to claim support from 'Three Great Medical Doctors.'"

This naturally leads to a very important point, that is, that organized medicine of Arizona and elsewhere for that matter should study carefully any project for which their endorsement is requested and further should be ever on the alert for implied endorsements of any project or activity and be quick to inform the public if these endorsements are not true.

YOUR PROFESSIONAL GROUP ACCIDENT AND SICKNESS INSURANCE PLAN A PROGRESS REPORT

DID you ever hear the expression "Good as Money in the Bank?" That is precisely what your Arizona Medical Association group insurance program has proved to be.

Total payments of the National Casualty Company if translated to the experience of ONE DOCTOR would provide disability income for 15½ years . . . with reserve equal to 5½ additional years.

$60,000 in benefits have been paid to members of your Associatoin since July 15, 1953. Present monthly benefit payments range between $2,000 and $3,000.

Yes, we say again, your group disability insurance program is money in the bank just when needed the most by members of the Association. We have received many letters expressing the complete satisfaction of members in the manner disability claims are handled by the National Casualty Company. Since all claim drafts are filed in the Association office, we are in a position to report that benefits are distributed promptly, regularly and quietly to members in all parts of the State of Arizona.

Although the payment of claims is high, I am told it is in keeping with the predictable loss ratio for a contract which is as liberal as ours. The plan will approach peak efficiency as the number of members who participate increases.

During the past six months, 62 members have added this coverage to permanent insurance program. Information and details may always be obtained by communicating with this office. Not only are new members accepting the insurance during their sixty-day non-medical enrollment period, but many other doctors have obtained this coverage by submitting Evidence of Insurability.

Just a word on the Extended Disability contracts. The cooperation of the membership resulted in enrollment of 84% of the eligible membership, more than the 75% required by the underwriter. This guaranteed the success of the offering and ALL applicants received policies. Through this program we have obtained coverage for certain members who have serious medical histories and have assurance that all new members will be accepted for both Basic and Extended coverage.

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TOPICS OF *Current Medical* INTEREST

RX., DX., AND DRS.

By Guillermo Osler, M.D.

DOES MACY'S tell Gimble's? Does one drug producer tell another? The Hyland Laboratories of New York gives full credit to Pfizer's for summarizing the data on **Agammaglobulinemia**, and for the suggestion that "parental administration of gamma globulin once monthly has provided excellent protection" . . . The big-hearted attitude probably stems from the fact that Pfizer does not produce G.G., but Hyland does ('Poliomyllitis Globulin—Human').

A search has been going on for some years to find a name for THE PHYSICIAN IN GENERAL PRACTICE. He has been called a 'general practitioner,' which is too cumbersome; a 'G.P.,' which can be confused with a laboratory animal; an internist,' which is too confining; etc. . . . A recent cover of the Journal of the Michigan State Medical Society (which is too long a name in itself) has used a title which may call the turn on a better name — the 'GENERALIST.'

The 'Generalists,' as represented by their journal 'G P' (of the American Academy of General Practice), have attacked a hospital routine which has seemed so usual that we all presume it is fixed and invulnerable. Maybe so, but they editorialize that the **'shutdown of hospitals on weekends** has serious medical and economic disadvantages. Week-end lulls discourage admissions, hold up service, and can be a hazard to patients.

An unknown author has produced the following quotation — "Nothing in life or disease is static. This makes living and the practice of medicine worthwhile."

Another saying, probably not new even in Hippocrates' time, says "News is never as good or as bad as it first appears."

An old topic in this column has been ANTI-RABIES TREATMENT. We have speculated on the value of the old stuff, and the certainty that new material would be devised . . . A report from the W.H.O. in Switzerland describes "the highly successful results" from combining the traditional VACCINE with hyperimmune antirabies SERUM. This combination of vaccine and serum is particularly useful for bites on the head and face, in which a serious progress occurred before the old vaccine could become effective.

The national total of **suicides** is probably 50,000 per year. The **prevention** of suicide depends largely on the recognition of the pre-suicidal states . . . Half of those who attempt suicide have psychoneurotic depression, a few have organic diseases, and the remainder are psychotic. About 70% of the depressions are in manic depressives, and the others are either involutional or schizophrenic . . . Symptoms which have no organic basis should be evaluated. Insomnia is an early symptom of depression, and the patient may pace the floor or smoke at night. Anorexia may be present, and cause loss of weight and constipation. Lack of usual interests, loss of libido, and concern over potency are all signposts . . . One should not send depressed patients on a vacation, or give them a supply of barbiturates (since 20% of suicides are due to the latter) . . . Saving the patient may be of wider usefulness, since one out of six attempt to kill others before trying self-destruction.

The pendulum has swung away from a complete absence of MASTOIDECTOMY on the surgical list to its use in a few per cent of the acute 'ears' . . . The reasons seem to be, according to Davison of Geisinger Hospital (Pa.), that myringotomy has not been performed, or that penicillin has not been used enough or at all . . . Adequate dosage, incidentally, is said to be 3 million units per day for children under the age of six, and double that amount for those over six.

A recent publication in the Journal of Urology describes the use of 'Clorpactin 90' as a new topical germicide in **tuberculosis cystitis.** It not only kills M. tuberculosis, it is said, but is effective against proteus and aeruginosa . . . There are two odd things about this announcement — no previous publication about it has occurred in TB journals, but this report is co-authored by John Lattimer who is 'Mr. GU TB.' We'll have to hear more.

There has been considerable confusion about the terms used to describe the substances from, or affecting the ADRENAL CORTEX. At the risk of compounding this disorder we jot down a few descriptions . . . The cortical stimulating drug is ACTH, or adrenal corticotropic hormone. The general term to describe the substitution materials is adrenal cortical steroids, or (more briefly)

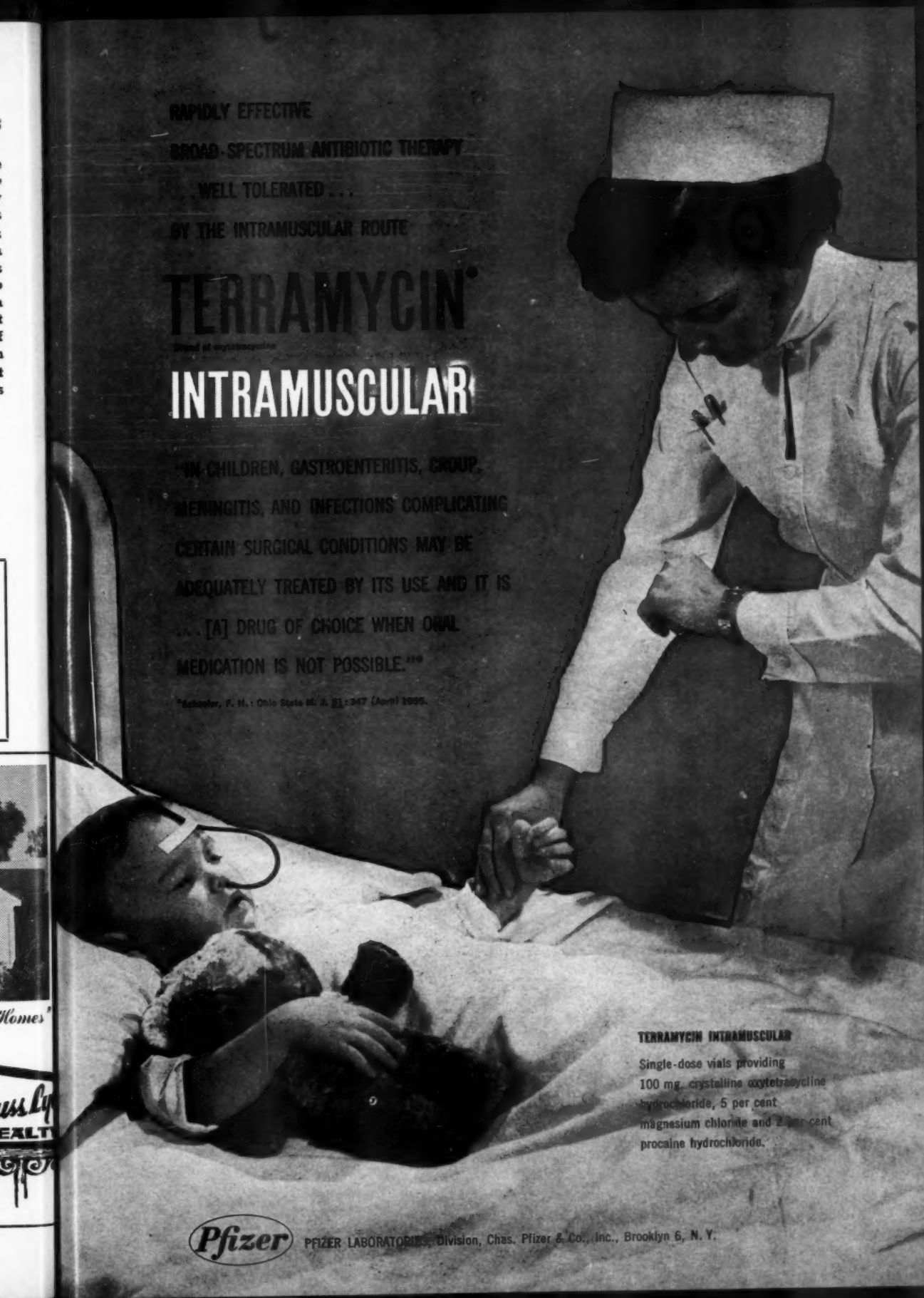
corticosteroids, or steroids. The analogs of cortisone (which has been the major steroid) are metacortandracin (called prednisone) and metacortandralone (called prednisolone) . . . The trade names will have to be figured out from this list, but you can guess the derivations of 'Acthar,' 'Cortone,' and 'Meticorten.'

A California state hospital has allowed its **sex offenders** to publish a booklet dealing with their problem. A therapy 'team' is used to rehabilitate them, and consists of a psychiatrist, a psychologist, a psychiatric social worker, and a rehabilitation therapist . . . They like the idea that treatment of their problem should be "medical rather than punitive." Nine out of ten offenders are at large, they say, and the offender does not know of his abnormality until the first commission of a crime . . . An enlightened attitude is logical, but can only work if a 'team' is available, and if the judge can be persuaded to take the right 'therapeutic' view of a sordid crime.

AN IMMUNOLOGIC PHENOMENON described by Drs. Peterson and Campbell of the Ag and Medical schools in Minneapolis has considerable medical promise. They have vaccinated cows against various diseases and proved that humans who drink the milk will show antibodies . . . The immunity is 'passive' and temporary, and continues only as long as the milk is ingested . . . Medical practice is doing quite a few things for the farmer, including buttermilk, skim milk, protein milk, sodium-free milk, et al. Now we may be able to use it for immunizing.

Our friend C. D. Leake (who 'lives' in this column, along with W. Alvarez, P. Samson, F. Meleney, et al) has just written an article in 'Postgraduate Medicine' on **"Drug Allergies"** . . . He subdivides the manifestations of drug reaction into those localized in special organs or tissues (hives, diarrhea, hay fever, agranulocytosis); those with generalized acute symptoms (such as anaphylactic shock); and generalized mild reaction (fever) . . . Any chemical having a carboxyl, hydroxyl, or amino group can combine with various amino acids to form a complex capable of cellular sensitization. The list of such drugs runs the gamut from salicylates thru barbiturates and halogens to antibiotics . . . His suggestion for the best management includes prompt withdrawal of the drug, administration of corticosteroids, and the use of such a cellular stabilizing agent as ascorbic acid. Easier said than done, of course.

The recent Eisenhower episode has caused the public (and the medical profession) to enquire about the TREATMENT OF AN ISCHEMIC MYOCARDIUM . . . We have heard that Mr. Eisenhower was given a narcotic, plus papaverine, plus an anticoagulant. We probably will hear more than these few items about his case . . . A positive but possibly drastic approach to coronary artery disease is CARDIO-PERICARDIOPEXY. This method was first used by Thompson and associates in 1939, and in the past ten years has been given a fairly good trial. Several series of 45 to 55 cases have been treated by the instillation of talc (2 to 4 drams of sterile magnesium silicate) thru a small anterior incision. The results include about a 10 per cent mortality, a partial success in half of the remainder, and a good result (in health and ability to work) in the other 40 per cent. It is a daring thing to try, but the alternative is bleak.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*Schaefer, F. H.: Ohio State M. J. 61:347 (April) 1965.
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DEPORT OF DELEGATE

Boston Clinical Session, House of Delegates Meeting,
American Medical Association
Jesse D. Hamer, M.D., Delegate

YOUR Executive Secretary, Mr. Robert Carpenter, and your Delegate attended all the meetings of the A.M.A. House of Delegates, held Nov. 29 thru Dec. 2, in Boston.

This Report on Actions of the House of Delegates cannot be covered in detail in this report because of the great length required. It is hoped that a brief summary of some of the more important actions, however, will be of interest to the members of our State Association.

During the Clinical Session annually, the President of the A.M.A., the Board of Trustees, Secretary, Treasurer, all the Standing Councils and Committees present their annual reports. These are all printed in a handbook for each Delegate for his information, and use of the various Reference Committees to whom all reports are submitted for comment and recommendation to the House. Many of these will be published in the Journal of the A.M.A. in current issues, and furnish the reader with several hours of interesting material covering the whole sphere of A.M.A. activities.

Blue Shield Prepayment Health Insurance

One resolution dealt with "Medically Sponssored Voluntary Prepaid Medical Care Plans," and the two "resolves" said:

"Resolved, That this House of Delegates commends physicians and the medical society sponsored plan in which they participate for the important services being rendered in health care for the American people; and be it further

"Resolved, That the A.M.A. reaffirm its approval of medical society sponsored non-profit prepaid medical care plans as a means for financing medical care."

The reference committee adopted this resolution which was introduced by Delegates from Connecticut and Massachusetts.

The other resolution, introduced by a Delegate from Ohio, dealt with the subject "Blue Shield Prepayment Health Insurance."

After commending the accomplishments of the Blue Shield Association of Medical Care Plans, the House resolved "That this House of Delegates commend professional sponsored non-profit insurance to the American public."

Social Security

All members of the American Medical Association have, by this time, received a personal letter from the President of the A.M.A., and an analysis of the Social Security Amendments contain in a bill H.R. 7225 passed by the House of Representatives last July. It is hoped that this communication will have the effect of stimulating you, your colleagues, auxiliary members and all patriotic Americans, at all community levels, to take militant action against this legislative proposal. The Senate Finance Committee (Senator Harry F. Byrd, Chairman) will hold hearing on this bill shortly after Congress convenes in January. The A.M.A. as well as many other organizations, will present testimony in opposition to the measure at the hearings. However, this is not enough. If American Medicine is to halt the steady march to Socialism and defeat H.R. 7225, it is going to require the writing of thousands of letters and wires to our Senators and to Senator Byrd. Local educational campaigns on the implications of HR-7225 should be conducted and every legitimate medium employed to focus wide public attention on HR-7225. The following actions were taken on this bill at the meeting in Boston.

Major legislative policy action taken at the Boston meeting involved H.R. 7225, known as the Social Security Amendments of 1955. This bill, which was passed last summer by the U.S. House of Representatives and is now pending before the Senate Finance Committee, includes a proposal for federal cash menefits to selected individuals judged to be permanently and totally disabled. The House of Delegates adopted a substitute resolution proposed by the Reference Committee on Legislation and Public Relations to combine the intent of four resolutions and three supplementary reports of the Board of Trustees dealing with H.R. 7225 and other aspects of Social Security. The substitute resolution stated the following policy:

"That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment upon the American system of medical practice which would be detrimental to our patients, the American people;

"That the American Medical Association urge and support the creation of a well-qualified com-

mission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective non-political improvements to the Social Security Act, for the benefit of all of the American people;

"That the American Medical Association pledges its wholehearted cooperation in such a study of Social Security in the United States, and will devote its best efforts to procuring and providing full information on the medical aspects of disability, rehabilitation and medical care of the disabled, and

"That copies of this resolution be transmitted to the President of the United States, to all members of the Cabinet, to all members of the Congress, and to all constituent state medical associations."

OASI Coverage of Physicians

In another action on social security, the House Passed the following resolution designed to determine the exact attitude of physicians toward compulsory or voluntary coverage under the social security system:

"Whereas, Misunderstanding exists about the position of the medical profession on the question of the inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act; therefore be it

"Resolved, That the House of Delegates of the American Medical Association recommend to state societies that they poll their entire membership on this question and that the results of the poll be transmitted to the Board of Trustees of the American Medical Association as soon as possible." Our State Association conducted such poll of its membership in 1954, with approximately 60% replying.

Report on Medical Practices

The House passed a substitute resolution offered by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practices (Truman Committee), which studied the basic causes leading to certain unethical practices and unfavorable publicity. The resolution, adopted with the proviso that it is subject to review by legal counsel, includes the following points:

"That a Continuing Committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical and surgical services and to report its findings and recommendations to this House in the same manner as is now followed by other committees and councils of the Association;

"That this committee shall consist of five members of the House appointed by the Speaker, three of whom shall be general practitioners;

"That this committee be directed to utilize all possible means to stimulate the formation of a department of general practice in each medical school;

"That the American Medical Association approve of the medical school teaching programs which afford the medical student opportunity for experience in the general practice of medicine;

"That the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the County Medical Society concerned;

"That this committee cooperate in every way and assist the Public Relations Department of the American Medical Association to present a program of public education designed to bring about a better understanding of all fields of medical practice, and

"That this committee use its full influence to discourage any arbitrary restrictions by hospitals against general practitioners as group or as individuals."

In a complementary action on the same subject, the House also approved a supplementary report of the Board of Trustees which included the following suggestions:

1. All non-surgical groups should be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical work.

2. The various specialty boards should be encouraged to reappraise the practice restrictions on their board diplomates.

3. The American Medical Association should continue to discourage arbitrary restrictions by

hospitals against general practitioners.

4. Organized medicine is "ready, willing and able to solve satisfactorily its own problems, and such assurance should be given to the American Hospital Association or any other group concerning itself with such problems."

Guides for Grievance Committees

The House approved the report of the Committee to Recommend Guides for Grievance or Mediation Committees and commended the committee for "their superb approach to this problem." Purpose of the guides is "to promote general uniformity of organization and function of grievance committees — and better understanding of their purposes — without interfering with the inherent autonomy of constituent medical associations. Constituent associations are therefore urged to implement these guides without delay."

The Reference Committee on Miscellaneous Business made the following recommendations which were adopted by the House:

"Your reference committee desires to support the recommendation that a brochure be published promptly which will outline the recommendations regarding the activities of Grievance Committees and that this brochure be given wide distribution.

"We recommend also that there be an appendix to this brochure in which additional, practical suggestions shall be included.

"We desire also to support the contention that there should be no equivocation concerning the naming of such committees and we recommend that a uniform policy be adopted in which they are called frankly 'Grievance Committees.'

"Finally, your reference committee recommends that because of the many variables, including the laws of the several states, which may influence the operations or procedures followed by State Grievance Committsee, legal counsel shall be sought at the local level within the states."

Medical Ethics

A proposed revision of the "Principles of Medical Ethics and Precepts of Manners of the American Medical Association" was submitted to the House by the Council on Constitution and Bylaws. The following reference committee suggestion was adopted by the House:

"In discussion it became evident that there was need for wide distribution of these principles and careful study of the proposed changes not only by this Reference Committee but also by all members of the House and in fact all members of the Association. It seemed desirable also that the two Councils (Council on Constitution and Bylaws and the Judicial Council) should meet in joint session to consider these proposals. Your Reference Committee therefore recommends that these proposals be tabled for further consideration at the next annual session of the House to be held in Chicago in June, 1956.

"In the meantime, it is recommended that these proposals in their entirety be widely publicized and that consideration be given to publishing, in the Journal of the American Medical Association and also in state medical journals, these proposed changes in the Principles. It is also recommended that consideration be given to the mailing of copies to each member of the Association. Finally, your Reference Committee recommends that prior to the meeting in Chicago next June the Council on Constitution and Bylaws and the Judicial Council meet in joint session to consider these proposed changes."

In another action on revisions of medical ethics, the House also approved a plan requiring that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final adoption.

Miscellaneous Actions

Among many other actions on a variety of other subjects, the House of Delegates also:

Recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contribution to the American Medical Education Foundation;

Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services";

Recommended that further purchase and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution;

Approved appointment of an A.M.A. committee to study the prevention of highway accidents;

Commended the Women's Auxiliary of the A.M.A. for its financial contributions in sup-

port of medical education and requested the Auxiliary to continue its active efforts;

Commended the Sears Roebuck Foundation for its thoughtfulness and foresight in sponsoring the new plan for financial assistance in establishing medical practice units;

Received progress reports from the Commission on Medical Care Plans and from the A.M.A. Law Department on its studies of professional liability;

Approved a Board of Trustees recommendation that the State Journal Advertising Bureau be separated from the American Medical Association and be given full autonomy;

Congratulated the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual, and

Approved the selection of Minneapolis for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.

Opening Session

Dr. Elmer Hess, A.M.A. President, told the opening session of the House that complacency should be regarded as the medical profession's greatest enemy. Although good progress is being made in informing the public and the profession of the objectives of organized medicine, he said, educational efforts must be intensified and the list of physicians' tangible accomplishments for the health benefit of the public must be increased.

Dr. Leo H. Bartemeier, Chairman of the A.M.A. Council on Mental Health, told the House that the new Joint Commission on Mental Illness and Health will be ready to embark on its nation-wide study and re-evaluation of the human and economic problems of mental illness after the first of the year. Dr. Bartemeier, who is Chairman of the Board of Trustees of the Commission, appeared before the House to explain the functions of the new commission, which was organized to carry out the Mental Health Study Act passed by Congress earlier this year, without a dissenting vote in either house.

Addendum:

Your Delegate attended the regional meeting sponsored by the A.M.A. in Omaha, Nebr. on October 15, for the purpose of discussing physicians' attitude toward a number of legislative bills which are pending, or will be introduced into Congress during this session, and again in Chicago, October 21, a meeting called by the Board of Trustees of the A.M.A. for the purpose of considering a feasible program which will help defeat H.R. 7225, the Social Security Amendments of 1955. This meeting was attended by representatives of all but two of the constituent State Associations, and the broad policies of approach to this question were worked out, with the help and counsel of the Department of Public Relations and the Public Relation firm of Borzell and Jacobs. These policies were adopted then by the House of Delegates as outlined in the preceeding pages under the subject of Social Security.

On October 16, in Omaha, Nebr. a regional meeting was attended which was sponsored by the Law Department, and the Medico-Legal Committee of the A.M.A. This meeting was in the nature of a Medico-Legal Symposium, and dealt with many of the problems confronting medicine, the legal profession, the courts, insurance companies, industrial commissions, and others, and the information and knowledge gained by attending this conference will serve in a very beneficial manner to our own State Association Medico-Legal Committee, which was created by action of your Medical Council last June. A more detailed report on these conferences was submitted to Council during its meeting on November 29, 1955.

Respectfully submitted

Jesse D. Hamer, Delegate

Phoenix, Arizona.

Organization PAGE

CIVICS

Norman Ross, M.D.

BOY SCOUTS OF AMERICA
ROOSEVELT CHAPTER

George F. Miller, Scout Executive
202 East Earll Drive, Phoenix, Arizona

FROM the July Issue: "Of interest state-wide is the notice from the Maricopa County Medical Society of a new policy on pre-camp health examinations. The examination, a screening type, is to be conducted by any and all members of this society without charge.

Only members of approved youth agencies are accorded the privilege of these free screening type examinations."

The following is a report from Mr. Miller of the effect of this program on his agency:

"It was with considerable skepticism that we learned early in 1955 of the new plan of conducting physical examinations for Scouts prior to Camp attendance. We were fearful that many boys would arrive in Camp without their exams and that we would be faced with innumerable tales of delay, etc.

Now, at the conclusion of Camp, we are more than grateful with the results of the new program. We had a few campers each session who arrived with no physical exams due to not having completed their appointment with the Doctor, and another small group who merely left the exam blank at home. This experience is about normal as compared with previous years as we have always been faced with this problem.

We feel that the new plan avoided the mass production set-up of the past where two and three hundred boys were examined in a single evening by a panel of doctors and feel that the individual boy possibly received a more thorough examination under the new plan than he did under the old plan.

Our Camp Doctor, of course, conducts a Camp re-check on every boy on his arrival in Camp and in no case this summer did he find symptoms that had not already been noted by the original pre-camp examination.

We want to take this opportunity to thank the Maricopa Medical Association for their splendid cooperation not only in this pre-camp physical exam set-up but also for their cooperation in other Scouting matters during the past year."

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AMERICAN RED CROSS
MARICOPA COUNTY CHAPTER

329 North 3rd Avenue, Phoenix, Arizona
Mrs. Harvey Samuel, Secretary, Nursing Service

Of particular interest to physicians outside of Maricopa County is this program of the Red Cross as there may be a similar program in your area.

"Starting January 9, 1956, we are holding classes for expectant parents in Mother and Baby Care. These classes will meet Monday and Thursday evenings at Red Cross Headquarters. The course consists of six two-hour sessions, and are held from 7:30 to 9:30 P.M. in order that the expectant fathers may attend. As registration is limited to twenty per class, anyone interested is urged to telephone Red Cross to register.

A swimming for handicapped persons program has been set up, following an outline set up by National Red Cross. Any doctor interested in this program may obtain an outline and more information by calling Red Cross."

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NATIONAL FOUNDATION
FOR INFANTILE PARALYSIS

Public Relations Department
120 Broadway, New York 5, New York

EDITORIAL #2

"Now – for the first time – we have an effective means for controlling polio. The Salk vaccine, in the most extensive and careful field trial ever given a vaccine, was shown to be 60 to 90 per cent effective in preventing paralytic polio. The vaccine now being manufactured is even more effective.

"Every parent naturally has questions about the vaccine. Foremost is the question: Is the vaccine safe? The answer to this is yes. Last

spring, according to a U. S. Public Health Service report, live virus was found in a small amount of vaccine that had been released. More stringent government safety standards were promptly established to prevent a recurrence of this incident.

The difficulties of a single manufacturer do not, of course, reflect on the safety of all commercially produced vaccine, any more than the existence of one contaminated source of water suggests that water itself is unsafe.

During last summer there were suggestions that a single shot of the vaccine might give some protection against paralytic polio, and so parents may wonder if such an injection is not enough. The answer is that it is not enough for full and lasting protection.

The child with one shot has some help in defending himself against paralytic polio. The child with two has even more help. The child with three, properly spaced, has the full protection of the vaccine.

Everyone would like to know how long the effect of vaccine lasts. And no one can give a hard and fast answer, because we have not had the vaccine very long. A number of children who have received it will be followed through the years until we do know how long it protects.

However, because the level of protection after the third shot is so high, there is reason to hope that it will last for many years.

The third shot is in a sense the real key to the effectiveness of the vaccine. This is why we will look with growing interest toward the 1956 polio season. By that time enough youngsters should have received their complete series of injections to make a substantial difference in the nationwide polio rate. Then we will be able to look forward to final control of polio within a few years.

This past fall the vaccine program of the National Foundation for Infantile Paralysis was concluded in school clinics in all states. In these clinics youngsters from the first and second grades received their second shots of vaccine, and so did third and fourth graders in schools that participated in the 1954 field trials."

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ARIZONA TUBERCULOSIS AND HEALTH ASSOCIATION, INC.

111 East Willetta Street, Phoenix, Arizona

The Arizona Tuberculosis and Health Association's October symposium was called for the purpose of obtaining a report on the progress of the state under the new TB Control Act of 1955. Reporting were representatives of the State Health Department, Maricopa County Health and Welfare Departments respectively, Pima County General Hospital, and Maricopa County Hospital.

As could be expected, the actual case load figures were *somewhat skimpy* as the act had been in effect for only one quarter. The problems of implementing the act were discussed at length. Throughout the meeting all speakers expressed pleasure with the spirit of cooperation met in all corners of the state as the administrative leaders in the various counties came to understand the meaning of the act.

With the cooperation of the local health units, county medical societies and interested community groups, a series of diagnostic and chest clinics is being arranged by the Arizona Tuberculosis and Health Association.

Serving as the committee planning this project are Drs. O. J. Farness; Lloyd K. Swasey; A. E. Russell; and Millard Jeffrey, Chairman.

These clinics will be in the nature of a demonstration for those areas of the state which currently are not receiving such a service. It is hoped this demonstration will lead to the effected expansion of the TB Control Program in Arizona. The committee is arranging for a panel of chest specialists who will assist in carrying out this program in the various localities where such a demonstration is indicated.

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From time to time on this page we have pointed to the increased scope of our responsibility to our patients in matters of insurance coverage and as relates to their medical-legal and economic problems. We suggested in the May, 1955 issue that this matter would be dealt with by a local attorney in articles on this page.

We are pleased to report that a joint committee of the Maricopa County Bar Association and the Maricopa County Medical Society has published a Guide For Physicians and Lawyers in The Handling of Problems Arising Out of Personal Injury Litigation. The articles by a local attorney are not, therefore, necessary.

Members of the society in our state can obtain this pamphlet by addressing the Arizona Medical Association, Security Building, Phoenix, Arizona.

NAT'L FUND FOR MEDICAL EDUCATION
COMMITTEE OF AMERICAN INDUSTRY
MEDICAL ADVISORY COMMITTEE
2 West 46th Street, New York 36, N.Y.

The following relates to an announcement of a 13½ minute documentary film on medical education and can be obtained by addressing a letter or post card to Earl C. Bonnett, M.D. and Robert C. Page, M.D., Co-Chairmen:

"The film is in black and white, with sound, and it dramatically covers the highlights of medical education in America. It was produced in collaboration with medical school deans and educators, the "cast" comprising teachers and students, nurses and staff in the schools and teaching hospitals.

The Fund wants to make sure the picture is viewed as widely as possible, since it brings home to lay and professional audiences the time and skills that go into medical education — and the need to preserve our medical teaching programs.

We are hopeful that you may find it possible to bring the film to groups in your area — to workers and executives in industry, to medical and lay organizations. The film provides an interesting quarter hour. A kit containing "before and after" remarks and simple program ideas is available to help you set up a good meeting."

* * *

MILHER, INC.
9 Buttles Avenue, Columbus, Ohio
Robert E. S. Young, M.D., President

This non-profit organization devoted to industry's medical problems announces that they have developed in the Department of Preventive Medicine at the Ohio State College University, College of Medicine, a residence training program in Industrial Medicine. A residency is now available to a citizen of the United States with a minimum of one year's training in a rotating or other acceptable internship as a pre-requisite.

"The first two years of the residency training is spent in a program of toxicology, industrial hygiene, safety engineering, industrial compensation law, coordinated with in-plant industrial medical training, in the plants available for teaching, the largest of which is North American Aviation, Inc.

In the third year of the residency, the resident has a choice of program. He may continue in advanced industrial medicine; or, in cooperation with the Civilian Aeronautics Administration Research Facilities and the School of Aviation Medicine at The Ohio State University, he may elect to specialize in Aviation Medicine; or he may elect to spend the third year in Atomic Medicine at The Ohio State University.

The fourth-year training is to be devoted to research projects.

The salary for the first two years is $300.00 per month, thereafter it rises to $500.00 per month. To date, Milher Inc. has paid all resident and intern salaries and has largely supported the remainder of the program. The program is in its fifth year."

* * *

INTERNATIONAL COLLEGE OF SURGEONS

The Mid-Atlantic Section of the International College of Surgeons is holding a regional meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia, February 13-14-15.

Papers are planned for the morning sessions with afternoons devoted to recreation or entertainment. For reservations direct your inquiries to the Greenbrier.

ARIZONA *Pharmaceutical* PAGE

THE PHARMACIST AND CIVIL DEFENSE

By Joseph Zapotocky, Ph.D.
College of Pharmacy, University of Arizona

THE Civil Defense Advisory Committee of the Arizona Medical Association, **Arizona Medicine**, and the collaborating authors are to be congratulated on the August issue of **Arizona Medicine** which featured civil defense. This compilation is a valuable contribution to a sound civil defense program needed both locally and nationally. It emphasizes the presence within this state of an informed and alert nucleus which is prepared for service in the event of a major disaster.

The pharmacists too are preparing to assume their share of responsibilities during such an emergency. Both the American Pharmaceutical Association's and the Arizona Pharmaceutical Association's Journals have kept pharmacists abreast of civil defense programs and of the role each pharmacist will be expected to play in this event. Civil defense bulletins have alerted the pharmacists of the state for a variety of duties. Previous experience qualifies them to handle the distribution of medical supplies in an emergency as they are and would be most familiar with the source, availability of drugs and supplies, limitation of supply and the preparation of drugs. There is perhaps no one other than the pharmacist, who is more aware of the numerous drugs possessing similar structure and activity which are available under a myriad of names, dosage forms, and strengths. In the absence of the physician, the pharmacist can advise of the correct use and administration of drugs.

Most pharmacists are either familiar with standard first aid procedures or are qualified first aid instructors. If during a disaster physicians are short handed, the pharmacist can be counted upon to administer first aid to relieve physicians for the arduous task of attending the more seriously injured. With estimated casualties in the hundred thousands and millions, in the event of a surprise attack, the potential assistance of pharmacists should not be overlooked.

The handling of narcotics and expensive drugs in great demand will require careful supervision by pharmacists to prevent the illegitimate use or loss of vital medical supplies to black market operators.

The strategic position of pharmacies throughout the country makes them useful for disseminating civil defense information to the public. The pharmacists who man them have already made valuable contributions toward educating the public for an emergency. In many communities, pharmacists have taken the lead in organizing civil defense programs for their area and in arousing the public interest in first aid programs.

The wholesale, retail, and hospital pharmacists of Arizona have inventoried their emergency medical resources and are increasing their supply of those items which may now be in short supply but which would be needed in large quantities in an emergency. Thus, the medical profession can count on the necessary supplies during an enemy attack. Pharmacists have also been assigned to each casualty clearing unit. Means of supplying the various first aid and emergency hospital stations are being studied. Much work remains to be done to perfect plans which are feasible and realistic.

No one group of the health team can act independently of the others. Doctors, nurses, and pharmacists have still to make great strides in coordinating their efforts into one master plan of operation in order to utilize each group to its greatest advantage. The plan cannot be adopted until each phase has been tried and tested for its practicality. Haphazard plans will only add to the confusion and the heavy toll of life during a disaster.

Notes from the EDITORS PEN

CREEPING GOVERNMENT MEDICINE

The Washington Office of AMA in submitting its third annual report on federal health spending, a factual study based on budgets, appropriation bills, and information obtained directly from government agencies and departments, merits pause for review and a few searching questions.

This year the Department of Health, Education, and Welfare with almost a ⅓ increase reaches a new high mark in spending for health and medical programs—more than half a billion dollars. Only two other agencies' medical spending is over the half billion figure, Defense Department and Veterans' Administration.

Compared with last year, HEW is spending 32% more in the health fields. The increase — $127,754,900 — is explained largely by sharp boosts in funds for Hill-Burton hospital construction, for vocational rehabilitation, for medical research and for the medical care of the indigent, and by a $30 million appropriation to purchase Salk vaccine and finance inoculation campaigns.

Total federal health spending also will reach a new high of over two and one quarter billion dollars during the current fiscal year, about $2,268,800,000, a 6.4% increase over last year. Even in a national budget well up in the billions, this figure for federal medical-health spending is not inconsequential. It is about 15 times the amount needed to maintain Congress and the federal courts, 14 times the total budget of the State Department, and 4 times more is spent by either the Labor Department or the Post Office Department. Expressed another way, Uncle Sam puts up $15 of every $100 spent by the American people (publicly and privately) for health and medical purposes, from purchase of toothpaste to financing cancer research. A frank discussion of the problem with your Congressman and mine is long overdue.

H.R. 7225—SOCIAL SECURITY

H.R. 7225 is the bill which cleared the House of Representatives without public hearing during the closing days of the current 84th Congress. It is now pending in the Senate Finance Committee and extensive public hearings during the next session are anticipated. This is the measure providing substantial amendments to the Social Security Act. Most controversial is the section making permanently and totally disabled persons eligible at the age of 50 to receive social security benefits presently not available until age 65. Medicine is opposed to compulsory cash disability benefits. Inevitably, medical care will follow and on down the line toward more socialization.

The bill will further lower the retirement age for women from 65 to 62; extend monthly benefits for permanently and totally disabled children beyond the age of 18; and extend compulsory social security to all self-employed professional groups except physicians. Payroll taxes in 1956 will go up 0.5% on both employee and employer, and 0.7% on the self-employed. This same proportionate increase will be applied in 1960, 1965, 1970 and 1975, at which time the tax will reach 4.5% (6.75% for self-employed).

Keep this bill in mind. Now is the time to confer with your Senators and Representatives. It will be difficult for politicians to oppose such increased benefits in an election year despite its further leaning toward more complete socialization. Each of us will have to do much to stem the tide. You will hear more on the subject in the weeks to come. Be informed and prepared.

AMA PRESIDENT

The membership a few weeks ago was privileged to receive and hear Dr. Elmer Hess, President of the American Medical Association. His inspiring address in open meeting brought many favorable comments which reflected credit upon American medicine. Many thanks, Mr. President.

CONGRATULATIONS—COUNCILMAN

It is not surprising that Joseph Madison Greer, M.D. of Phoenix was successful following the November election in Phoenix and led all candidates in total vote cast. He has always been a leader and we expect him to continue during his term of office. Congratulations, Dr. Greer, and best wishes. Phoenix is in for continuing Good Government.

Woman's AUXILIARY

HIGHLIGHTS OF THE 12th ANNUAL CONFERENCE

MRS. Roy Hewitt, President of the State Auxiliary, and I as President-elect attended the 12th Annual Conference of State Presidents and Presidents-elect and National Committee Chairmen of the Woman's Auxiliary to the American Medical Association at the Drake Hotel, Chicago, Nov. 1-3, and came away enlightened and encouraged—enlightened as to the status of legislation pertaining to health, mental health, Civil Defense Nurse Recruitment. Mrs. Hewitt discussed Medical Social Workers, a comparatively new field which provides retraining of the patient to face illness and adjustment to conflict, perhaps in the home, on the Nurse Recruitment panel. — And encouraged by our contacts with doctors' wives from all over the U. S.

Other panels which were of especial value for us in our planning were on Organization, Program, "Bulletin", and "Today's Health", which is offering a new special contest for subscriptions for registered nurses. The nurses may this year only subscribe for $2 between Jan. 15 and March 15. This contest could rightfully be a project for Future Nurses Clubs to push. There is a special prize of 20 gift subscriptions for the most nurse subscriptions, which may be given in the name of the County auxiliary which obtains them. Fifty cents of this sum is also kept by the local auxiliary treasury and the number of subscriptions is added to the total for the year.

The auto-safety film we saw points up Safe-Driving Day, which is Dec. 1, a day of special caution to avoid accidents. These films are available at the A.M.A. office. Another was on Medical Technician Recruitment and one on the A. M. E. F., sparked by Kate Smith. The American Medical Education Foundation has been established to assist medical schools financially. Less than one-fifth of their funds come from student tuition, and, of course, medical education costs, like all education costs, are increasing. The cost of maintaining a basic medical faculty is $1,250,000. In order not to let down standards of health care to the public, we will be alerting lay people of these facts during Medical Education Week, April 22-28, 1956, when we shall ask the public to contribute less than one dime for each of the 81 medical schools in existence on the 80-dimes card which you will receive. The October 8th Journal of the A. M. A. has an article on Education if you would like more information: also March 12, 1955, "Facts About Medical Students".

It is a myth, we were told, that only A students get into Medical schools. In fact, due to residence requirements, some state schools have difficulty filling their classes. The $8 on the card will educate one doctor for one week.

We learned that Public Relations has shifted emphasis from mass to individual. Thus each of us can have an effect on H. R. 7225, the bill which has passed the House and is due to come up in the Senate in the Spring, which injects medical service into the Social Security Act for the first time. Doctors will be asked to determine the condition of permanent and total disability of people over 50 who apply for cash benefits and agree to rehabilitation, if this bill becomes law. It would be a gigantic program, the tax take for which by 1975 it is estimated would be over 20 billions, if it remains constant. You will receive more information later, but be studying it now. The A. M. A. has never opposed Social Security per se, but now that it is expanding into the field of medical service, it feels the need to speak, Dr. Howard said.

Mrs. J. D. Hamer also appeared on a symposium, composed chiefly of National Past-Presidents, to tell us of the problem of the History Committee.

We left feeling that it had all been most worthwhile, and I wish to thank the doctors for making it possible for us to represent Arizona there.

MRS. OSCAR W. THOENY

PROFESSIONAL BUILDING DIRECTORY

	Phone	Room
Dentists (D.D.S.)		
General Dentistry		
Baker, William A.	AL 3-8529	1020
Boynton, C. E.	AL 2-7572	817
Butt, Byron G.	AL 4-2345	517
Chiles, George H.	AL 4-1211	618
Dunlap, Robert M.	AL 3-4312	702
Hensing, C. R.	AL 3-6603	819
Jesik, Peter	AL 8-3320	802
Johnson, William J.	AL 3-1866	919
Lee, Joseph A.	AL 4-2345	517
Leibold, John P. (Child only)	AL 8-3142	711
Pafford, Ernest, Jr.	AL 3-3807	718
Pafford, Ernest M.	AL 3-3807	718
Scott, E. M.	AL 8-4277	918
Sitkin, Frank L.	AL 4-2345	517
Smith, Franklin R.	AL 4-3257	717
Spillane, L. O.	AL 3-0461	821
Steninger, Milo C.	AL 4-3561	621
Voorhees, Joseph P.	AL 8-3320	802
Oral Surgery		
Bairo, Louis P.	AL 3-9362	711
Borah, Charles E.	AL 3-7414	814
Peterson, Ralph G.	AL 2-6313	719
Stallcup, L. B.	AL 4-3675	418
Orthodontists		
Jensen, Albert J.	AL 3-2327	617
Moffat, Richard P.	AL 4-1322	1017
Periodontists		
Burke, Wm. G.	AL 8-4644	818
Creamer, R. Dean	AL 3-6534	820
McGuire, Vaughn S.	AL 3-6718	1118
Physicians & Surgeons (M.D.)		
Cardio-Respiratory Diseases		
Randolph, Howell	AL 4-3146	1005
Dermatology		
Mackoff, Sam M. (A).	AL 2-0379	920
Medigovich, D. V.	AL 3-6617	905
Endocrinology		
Raddin, Joseph B.	AL 2-3577	619
Eye, Ear, Nose & Throat		
Barnet, E. G.	AL 4-3341	1120
Cruthirds, A. E.	AL 3-5121	1011
Gaskins, Duke R.	AL 3-8582	922
Johnson, James L.	AL 4-2841	806
Melton, B. L.	AL 3-8209	605
McCurdy, Gordon J.	AL 3-8209	605
Nelson, W. J.	AL 3-5121	1011
Reese, Forrest L.	AL 4-3341	1120
General Practice		
Barker, C. J., Jr.	AL 3-2176	710
Barker, Robert D.	AL 3-2176	710
Cohen, Matthew (S).	AL 3-6797	1006
Dysart, Palmer	AL 4-8483	1108
Felch, Harry J. (Ob.S.)	AL 3-1151	705
Holt, Clinton L.	AL 3-2883	520
Hussong, R. W. (Ob.G.)	AL 3-2883	520
Matanovich, M. (I.S.U.)	AL 3-6509	422
McKenna, J. F. (A).	AL 4-2174	910
General Surgery		
Bate, Thomas H.	AL 4-3326	803
Brewer, W. Albert	AL 3-4349	1116
Greer, Joseph M.	AL 3-2240	1111
Hansbro, G. L.	AL 3-8559	611
Ovens, J. M. (Tumor).	AL 8-8074	608
Ross, Norman A. (Diag.)	AL 3-8353	810
Shumway, Ord L.	AL 3-4349	1116
Internal Medicine		
Deitchman, Morris (Ca.)	AL 2-1802	1008
Gatterdam, E. A. (A).	AL 4-2174	910
Hamer, J. D. (Ca).	AL 4-2174	910
Hopkins, Doris F. (A).	AL 4-7509	402
Kober, Leslie R.	AL 4-4153	1105
McKhann, Geo. G.	AL 4-8483	1108
Milloy, Frank J.	AL 2-0142	611
Snyder, Bertram L. (Chest)	AL 4-2174	910
Swasey, Lloyd K. (Chest)	AL 4-2174	910
Obstetrics & Gynecology		
Barker, C. J., Sr.	AL 3-2176	710
DePinto, Angus	AL 3-9112	707
Smith, Gregory C.	AL 3-9112	707
Ophthalmology		
Aiello, John S.	AL 3-8582	922
Burgess, Roy E.	AL 3-5604	822
Franklin, Henry L.	AL 4-3738	805
French, Harry J.	AL 4-1670	722
Harbridge, D. F.	AL 3-5604	822
Pediatric Surgery		
Cloud, Daniel T.	AL 3-2933	706
Plastic & Reconstructive Surgery		
Lawrence, Howard C.	AL 8-4101	709
Proctology		
Jenkins, James T.	AL 2-2822	903
Meyer, Wallace M.	AL 2-2822	903
Psychiatry & Neurology		
Barrett, Robert S.	AL 3-1491	606
McGrath, Wm. Bede.	AL 3-5559	811
Radiology & Pathology		
Foster, R. Lee	AL 3-4105	507
Kennedy, John W.	AL 3-4105	507
Watkins, W. W.	AL 3-4105	507
Thoracic Surgery		
Melick, Dermont W.	AL 4-3146	1005
Urology		
Faulkner, James W.	AL 8-6884	808
Other		
Arizona Bancorporation	AL 2-4798	500
Laboratory of Clinical Medicine.	AL 4-9881	1106
McLeod Optical Company	AL 2-9201	522
Nurses' Professional Registry	AL 4-4151	703
Professional Building Office	AL 4-4406	500
Professional Garage.	AL 4-4833	Bsmt.
Professional X-Ray & Clinical Lab.	AL 3-4105	507
Seller, Irene H., Chiropodist	AL 4-1801	1021
Smith, C. J., CPA.	AL 3-9561	1022
Turner, F. Bernadette, Ph.D., Marriage & Family Counselor.	AL 3-0362	921
Valley National Bank.	AL 8-8711	Lobby
Valley National Co. (Ins.)	AL 4-2191	Lobby
VNB Car-Park	AL 3-2835	
Wayland's Prescription Pharmacy	AL 4-4171	Lobby